WORLD RELIEF RWANDA
"UMUCYO" CHILD SURVIVAL PROGRAM

First Annual Report
FY 2002

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ACRONYMS

AC	Area Coordinator
CBC	Communication and Behavior Change
CSP	Child Survival Project
CW	Concern Worldwide
DIP	Detailed Implementation Plan
FFH	Freedom from Hunger
HMIS	Health Management Information System
HQ	Headquarters
IRC	International Rescue Committee
KH	Kibogora Hospital
KHD	Kibogora Health District
KPC	Knowledge, Practice, Coverage
LRA	Local Rapid Assessment
MOH	Ministry of Health
NGO	Non-Governmental Organization
ORS	Oral Rehydration Salts
PVO	Private Voluntary Organization
PM	Program Manager
WR	World Relief
WRR	World Relief Rwanda

A. MAIN ACCOMPLISHMENTS

Two distinguishing characteristics of the *Umuyco* Child Survival Project (CSP) have become evident in year one and are helping to build a foundation for the program that will ensure success and sustainability of the CSP beyond the life of the project. The first is the commitment of the CSP team to capacity building. The entire Umuyco staff is new to the CSP approach and have needed to learn everything from KPC survey techniques to how to motivate volunteers from scratch. Jean Kagubare, MD, MPH a doctoral candidate at Johns Hopkins University Bloomberg School of Public Health (JHUSPH) and former Director of Planning for the Rwanda Ministry of Health (MOH), visited the Umuyco CSP in August 2002 to provide technical support to the team. He said he was impressed by the commitment level of the CSP team compared to the many other projects he has worked with. Their thoughtful questions and positive attitudes were evidence of their commitment to developing a successful program.

The second distinguishing characteristic of Umucyo is the commitment to collaboration with local partners including other CSPs in country. Monthly CSP coordination meetings are being held among the USAID-funded Private Voluntary Organizations (PVOs) and partners (International Rescue Committee (IRC), Concern Worldwide (CW), PSI, Unicef, MOH, USAID and World Relief Rwanda (WRR)). Over the last two months the focus of the meetings has been the development of a common set of indicators that allow the CSPs to compare progress in shared interventions. This level of strategic PVO collaboration is unique in the Child Survival (CS) community and will impact the quality and sustainability of each CSP involved.

Key achievements of the Umuyco CSP to date are highlighted below:

1. STAFF RECRUITMENT AND SYSTEMS DEVELOPMENT

Following the approval of the CSP proposal in May 2001, World Relief Headquarters (WRHQ), WRR and the Kibogora Health District (KHD) began to lay the groundwork for the CSP, which was officially scheduled to begin in October 2001.

At the official start, Sheila Etherington, a nurse from the UK with 20 years experience working in KHD was named Program Manager. Melene Kabadege, a Rwandan nurse with extensive experience working in KHD and a degree in Public Health, was named Assistant Program Manager. In December 2001, following completion of a trial period in which she proved her ability to lead the project, Melene was promoted to Program Manager and Sheila assumed the role of Special Advisor to the program.

Program support staff recruited for the central CSP office include an accountant (Andre Munezero), an administrative assistant (Jean-Baptiste Ayirwanda), and several guards.

In October 2001, WRR started renting a office from the Free Methodist Church in Kibogora strategically located adjacent to KH and KHD offices. Budgeted equipment including 2 desktops, printer, copy machine, and office furniture was purchased for the office. The program also procured a Toyota Pick-up and 18 motorbikes with accessories.

The KHD is divided into 6 regions: Yove, Rangiro, Karambi, Ruheru, Nyamasheke and Gatare. Six Area Coordinators (ACs) were hired at the start of the program, one per region, to supervise the training and work of promoters in each area. Two weeks in November 2001 were dedicated to training the ACs on the overall program approach, human resources, and management and monitoring techniques. ACs also received a course in basic computer skills and driving.

In January 2002, 30 promoters were hired to complete the paid CSP staff. Each promoter is in charge of an administrative sector and is responsible to train Care Groups of volunteers in the area and to supervise home visits by the volunteers. In February 2001, a one-week training session was organized to orient the promoters to the program. The schedule included the program approach, the promoter's role in the community, resource management, principles of adult education and communication, conducting home visits and interviews, and an overview of the national decentralization policy and government health structures.

2. BASELINE KPC AND DIP

The baseline KPC was completed in November 2001. The experience not only provided baseline data for setting indicators, but developed the core CSP staff's understanding of the region and investigation process. A full report of the process and outcomes was submitted with the Detailed Implementation Plan (DIP) in March 2002.

Translation of the complete DIP document into French is still in progress. The CSP staff initially planned to use CSP team members to complete the translation and thus allow the staff to review the content in greater depth. The sections covering the program approach and the first two interventions (diarrhea/hygiene and immunization) were completed in time for use by the CSP team to prepare for the interventions. Time constraints have not allowed the CSP team to finish the translation. The remainder of the document is being translated by an external consultant in Kigali. It will be finished by mid-November 2002.

The DIP is an extremely well researched document and provides extensive background information on the local situation for each intervention. Semi-structured interviews and other qualitative research was completed at the time of writing the DIP. This information has been essential to the program team as they develop the curriculum for the interventions. The DIP also provides information on management and reporting systems that have been used successfully in other WR CSPs in Mozambique, Malawi, and Cambodia involving the same Care Group approach. This information has not been fully utilized by the program management team as it has not been available in French but the concepts have been reviewed repeatedly by WRHQ with the CSP team.

Although a formal presentation of the translated DIP document has not been made to local partners, KHD leadership and other partners were involved in the writing process and are continually updated on the program strategy and progress. A discussion of the DIP was included in the promoter's training camp for immunizations held in mid-October and the Program Manager takes advantage of other meetings with project staff to continually reinforce the program and intervention strategy.

3. FORMATION OF CARE GROUPS

The Care Group lies at the heart of Umuyco. The selection of volunteers and the subsequent formation of Care Groups was a critical step in the development of the program. To ensure the quality of the volunteers the following steps were taken:

- Each promoter completed a thorough assessment of his/her region that included contacting local authorities, women associations, schools, MOH health animators, ANTI-AIDS clubs and other potential partners, as well as identifying the actual number of households in each nyumba kumi and accurately delimitating the promoters' zones at the cell level.
- Local authorities and program stakeholders including the Medical Director of KHD, District Mayors and sector/cell coordinators were consulted to define and supervise the selection process for volunteers. Criteria for volunteers include: availability, motivation, volunteer commitment, exemplary behavior, literacy, and age between 21 and 50.
- In April 2002, elections were held at the nyumba kumi level to select one volunteer per group of 10 households. Turnout by the community for the elections exceeded expectations. A total of 2,730 volunteers were elected for the two districts of Nyamasheke and Gatare and organized in 272 Care Groups. Following expansion of the program area in June (see below) an additional 159 volunteers gathered in 16 Care Groups were elected, bringing the total number of volunteers to 2,889 and Care Groups to 288.
- Each Care Group selected a representative or "Care Group Leader" to act as a primary contact for the promoter, to record data reported by Care Group members during biweekly meetings and to coordinate activities.
- During their first visits with the newly elected volunteers, the promoters conducted an orientation training, stressing the importance of the volunteer's attitude, and presenting the organization chart of the program, the concept of care groups and the training schedule.

The volunteer election process took more time than initially anticipated, delaying the progress of the program by approximately one month according to the DIP work plan. The delay is not a concern at this stage of the project. If possible, the CSP team will try to make up for the lost time. However since the final years of the program are focused on reviewing interventions rather than initial implementation, a one-month delay should not cause problems for the overall program.

Care Groups meet once every two weeks with their promoter to receive training in the lesson for the current intervention, report on home visits, and build community. Based on Care Group registers maintained by the promoter and Care Group Leader, volunteer attendance at Care Group meetings is currently averaging 75%, well above the minimal 60% attendance for an active care group.

4. FORMATION OF CHURCH LEADER CARE GROUPS

In addition to mobilizing groups of volunteers, religious leaders are being included in the program - about 400 leaders from 10 different church denominations have been organized into

11 pastoral groups and attend a quarterly training on each health intervention. Church leaders are extremely influential community leaders and key in building support for grassroots outreach and in encouraging their faith communities to adopt healthy behaviors. They debrief on each intervention with the promoters at the end of the training so the CSP team gets a feedback on content and approach.

The fruit of investing in church leaders is already being seen. Following the training on Diarrhea and Hygiene (see below), church leaders in the Gatare, Karambi, and Ruheru areas informed the CSP promoters about a local practice that was unhygienic. The population of these regions had recently started using and commercializing fresh human feces for soil fertilization. The CSP staff contacted the KHD to discuss the problem and look for solutions. The promoters reinforced the lessons on hygienic practices through the volunteers. The mayors overseeing the region also became involved and the practice is no longer commonly reported.

5. EXPANSION OF PROGRAM AREA

In June 2002, the catchment area of the CSP was expanded to include two administrative sectors (Kilimbi and Cyiya) in Rusenyi District of Kibuye Province that border the KHD. The district mayor of Rusenyi proposed the expansion, and following discussions with WRHQ and USAID Washington the expansion was approved. Although technically within the limits of the Mugonero Health District rather than KHD, the populations of the two areas frequently use the Kibogora Hospital and Health Centers because those in the Mugonero Health District are less accessible. Two additional promoters were recruited and report to the ACs of the Karambi and the Gatare area respectively.

6. STAFF DEVELOPMENT

The Program Manager continues to grow in her knowledge and ability to analyze data using EPI-info for KPC and LRA reports and program management. She attended a one-week training on EPI Info in December 2001 in order to prepare data capture and analysis for the KPC survey. A consultant visiting in August 2002 provided further training. She has seen the value of the program and would like further training in order to use it to its fullest.

In May 2002, Laura Van Vuuren, WRHQ Adult Education and Training Specialist, organized a one-week training for the ACs in Adult Education that included lessons on addressing an adult audience, conducting interviews and focus groups, and giving feedback. The ACs put their knowledge into practice as they presented the training to the rest of the team in Kibogora.

In May-June 2002, the Program Manager traveled to the USA to participate in the DIP review at USAID HQ in Washington, DC. The trip also her offered the opportunity to attend the Global Health Council and Christian Connections for International Health annual meetings.

In August 2002, Jean Kagubare, MD, MPH, who prior to becoming a doctoral candidate at JHSPH most recently served as Director of the Planning Directorate for the Rwanda MOH came as a consultant to assist the team in the development of the Health Management Information System (HMIS) and supervision techniques. He also introduced the Program Manager to key

partners within the national MOH including the Director of Health Facilities and Director of Quality of Care. Dr. Kagubare's two-week training included the use of EPI Info for data analysis, principles of statistical analysis and epidemiological surveys, review of MOH's Information System, project monitoring: performance indicators, data collection methods, interpretation and exploitation of results, Local Rapid Assessments (LRA), and management tools for project supervision.

Some members of the KHD staff also attended the training. This was important not only for capacity building of our MOH partner but also in helping to strengthen relationships between Umucyo staff and the KHD. Examples of program monitoring and reporting forms can be found in Annex A and will be discussed further in Section F.

7. DIARRHEA AND HYGIENE INTERVENTION

WR phases in interventions one at a time, giving staff and volunteers time to assimilate one intervention before adding the next. By teaching in smaller units, people have sufficient time to internalize and put into practice the information they are learning. Also, interventions can be timed during their greatest need (i.e.: malaria during malaria season, etc.)

Diarrhea and Hygiene was the first intervention scheduled for the Umucyo CSP. The month of May 2002 was dedicated to the development of the promoter and volunteer curriculums by the Program Manager, ACs and Promoters. The curriculum development process was highly collaborative, involving most staff members in one step or another.

The formative research completed for the DIP and results of the baseline KPC proved extremely helpful in understanding the context behind local practices, beliefs and knowledge. Local partners including the Director for Healthcare and Social Affairs of the Cyangugu Province, the mayor of Nyamasheke, the Medical Director of KHD, KHD administrator and Health Center staff attended a meeting to review the curriculum and ensure it coincides with existing guidelines. Following field testing by promoters in select volunteer and pastoral care groups, a promoters' workshop was organized to provide direct feedback on the curriculum with a particular focus on content, time management, methodology and teaching material. Input from all of these sources was included in the finalized curriculum.

The Diarrhea and Hygiene curriculum includes 8 lessons:

- What is diarrhea? Transmission and symptoms
- Hygiene of hands, water, and food
- Hygiene of household items, latrines and surroundings
- Hygiene of restaurants bars and markets
- Preparation of ORS
- Preparations of local liquids for oral rehydration (2 modules)
- Feeding a child that suffers from diarrhea

Key behavior change messages for the diarrhea/hygiene curriculum include the following:

- Immediately prepare and give Oral Rehydration Therapy (ORT) (ORS, home available

fluids) during diarrhea

- During and following an episode of diarrhea the mother should continuing breastfeeding/ giving small frequent feeds
- If a child has diarrhea he or she should be taken to the hospital or health center immediately if any of the following symptoms are present: a) diarrhea lasts more than 3 days, b) child has vomited several times, c) child is extremely thirsty, d) child has high fever or e) there is blood in stools
- Anti-diarrheals and antibiotics should not be used when a child has diarrhea
- Increase catch-up feedings during the 2 weeks after recovery from diarrhea

Based on this first experience in curriculum development, the CSP team realized that there is room for growth. Although strong in terms of technical content, the team recognizes the challenge it is to communicate the messages in a simple way that the community will understand, remember and above all apply. Participatory methods based on interactive questions and dialogues were used in the first curriculum but more stories, songs and sketches must be developed among the promoters and the volunteers themselves.

The following in an example of a song created for the promoter's training on Diarrhea and Hygiene:

'Let us fight against Diarrhea'

Let us fight against diarrhea in our community
Our children need a good health
Cleanliness of our hands and food
Water and fruit
That is what will help us

When your children start having diarrhea
Immediately give them a lot to drink
Mixture of salty fluids is necessary
Do not stop breasting them
This is what will help them

In case the patient has fever
In case of a diarrhea with blood or vomit,
In case of great thirst or when they refuse to eat
When diarrhea keeps coming back
Bring them quickly to hospital.

Training
In June 2002, training on Diarrhea and Hygiene started simultaneously in 272 Care Groups. The training of volunteers took a total of four months at the rate of one lesson every two weeks (each lesson includes a review of the previous lesson with a few questions). For the 16 Care Groups in the Kibuye extension zone, training started in July 2002.

Volunteers are called to lead by example and behavior change is often seen first in the lives of the volunteers. One volunteer named Anne-Marie Mukabahimi shared how the first intervention affected her personally:

> *Before starting the training in Care Group I never washed my hands before feeding my child but now it is starting to be a habit. I did not know that a child with diarrhea needs to be breastfed, but now when my child has diarrhea I breastfeed more than usual. Moreover, I prepare rice water and soups to give to the child that I learned to prepare in the Care Group. I wash my hands before breastfeeding. My husband built a shelf where I dry the dishes after washing.*

After each biweekly Care Group meeting, volunteers deliver the messages to mothers of their nyumba kumi. They typically organize one visit per day which enables them to visit all households during the two weeks between Care Group meetings.

To help the volunteers remember and apply the lessons they have learned and as an incentive for participation, a small manual summarizing the key points of the Diarrhea and Hygiene curriculum was produced, printed and distributed to all volunteers. The CSP team will seek to improve these teaching aids in future interventions so they will not just provide information, but help volunteers become more effective teachers.

In addition to volunteer training, a one-day training on Diarrhea and Hygiene was held with local religious leaders from the 11 Pastoral Care Groups. They not only appreciated the content of the lessons but valued the opportunity to meet other church leaders from different denominations. By encouraging dialogue and cooperation between leaders of various denominations, the program will more effectively reach the entire community.

Cholera outbreak

Timing for the interventions is key and the Diarrhea and Hygiene was providentially scheduled first. In early August, volunteers began reporting cases of severe diarrhea among some of the households in their nyumba kumis. The promoters reported their findings to the Program Manager who in turn notified the KHD and other local authorities. After further analysis by the KHD, a cholera outbreak was confirmed mid-September in the area of Nyamasheke. As of 30 September 2002, 105 cases were admitted to the KH– an average of 5 to 10 new cases have been admitted to hospital every day since and 2 people died shortly after arriving at the hospital. Eight sectors out of a total of 34 served by *Umucyo* have been affected. The outbreak has since been contained but cases are still being reported.

In spite of the difficulty it presents for the population, the cholera outbreak is an opportunity to reinforce the messages on Diarrhea and Hygiene. When the outbreak started, the KHD and CSP called on the volunteers to deliver a specific message on cholera to households. CSP promoters were in charge of reporting cases to the KHD in collaboration with the Care Group Leaders.

In the midst of an outbreak such as this one, education alone is not sufficient. WRR assisted KHD by providing medical supplies including ringers lactate, glucose, catheters, tubing sets and 10,000 packets of ORS. CSP funds were NOT used for these supplies.

The cholera outbreak also paved the way for a partnership between the CSP and PSI to have the CSP sell PSI's 'Safe Water' water purifier product. The MOH has been encouraging use of the product for some time and it is distributed using MOH Health Animators in other areas of the country. PSI trained the CSP staff in the use of the product and the CSP made an initial purchase of 2400 units. According to PSI policy, the volunteers will receive a small profit for each sale they contribute to. It has been decided that the promoters will keep the supply and volunteers bring mothers who wish to purchase the product to see the promoter after the Care Group meeting. The volunteer will still receive the incentive for the sale although he or she will not be directly involved in managing the supply or receiving money.

Evaluation
A Local Rapid Assessment (LRA) evaluating the impact of the Diarrhea and Hygiene was completed on September 26-27. A total of 415 mothers were asked questions relating to the intervention's behavior change messages. The results are shown below and compared to the baseline KPC when applicable.

	Num	Den.	%	Conf. Limits	Baseline KPC
Mothers who know 3 or more danger signs of diarrhea	274	415	66.0%	60-72%	83% for 2 or more
Mothers who practiced key behaviors in home management of their child's diarrhea (continued BF, give more fluids, give more food, and/or ORS)	80	112	71.4%	59.6%-83.2%	31%
Mothers who know 3 or more modes of transmission of diarrhea	288	415	69.0%	63-75%	
Mothers who know 3 or more ways to prevent diarrhea	346	415	83.4%	78.3%-88.5%	
Mothers who can name 3 or more occasions for hand washing	334	415	80.5%	75.2%-85.8%	

While baseline data for some of the questions asked on the LRA does not exist, the staff were especially pleased to see improvement in reported home management of diarrheal disease, from 31% at the time of the baseline KPC to 71.4% on the first LRA. The project will need to continue to reinforce messages and behaviors pertaining to diarrhea to sustain and even continue to improve changes observed to date. Seen in a broader context, improvement in home management of diarrhea is indicative that the messages are in fact reaching household level through the volunteer structure.

6. IMMUNIZATION INTERVENTION

The second CSP intervention focuses on immunization. Background information was gathered from the DIP, KPC report, KHD and the WHO. The proposed curriculum was presented to the KHD on 8 October for revisions and the promoters' workshop took place in mid-October. The curriculum includes 6 modules:

- The role of volunteers and other health animators in the immunization program
- Definition of vaccine and importance of immunization
- Understanding, diphtheria, measles, Hemophilus Influenzae, and tuberculosis
- Understanding polio, whooping cough, tetanus, and hepatitis B
- Immunization schedule for infants and pregnant women
- How to handle the side-effects of vaccines and drawbacks of not being immunized

Following field testing by the promoters and ACs, final revisions are currently being made to the curriculum before printing the reference booklet for volunteers. Compared to the Diarrhea and Hygiene curriculum the immunization modules put a greater emphasis on creative ways of spreading the messages including using drama, symbols, pictures, and dialogue. The CSP team is applying lessons learned in the May 2002 adult education training and growing in their skills. They look forward to more advanced training in this area.

In addition to community education, volunteers will report on immunization status and suspected cases. CSP staff will work closely with KHD personnel to improve consistent EPI outreach in the community and adopt a consistent strategy.

The baseline KPC showed that only 51% of children 9-23 months old were fully immunized by year one compared to 76% nationally, although an additional 25% were fully immunized after the first year. Strategies for reducing dropouts and missed opportunities will largely focus on educating mothers about how important immunization is and on increasing access to immunization for families living in cells farthest from the health center.

B. CHALLENGES

1. Transportation

CHALLENGE: The CSP purchased 18 motorbikes to assist the coordinators and promoters in their work. Unfortunately, at the time of writing, the staff has been unable to use the bikes. The prefecture's system for granting driving permits is supervised by the national police who make it extremely difficult for people to obtain official category A driving permits. Consequently, most drivers operate without an official permit and are not covered by any insurance. Thirteen CSP staff members passed their temporary driving license in July 2002 but they are not permitted to drive until they complete a practical exam. They have not been able to take this final exam yet as the police lost the original paperwork submitted by the CSP and have not issued the temporary licenses.

RESPONSE: The Kigali office of WRR was able to schedule an appointment with the Head of Traffic Police in Kigali on 22 October. Further to this meeting, temporary licenses were issued and a practical exam is scheduled on 9 November 2002.

CHALLENGE: Even with the aid of motorbikes, KHD includes areas that can be particularly difficult to access due to slippery roads and poorly maintained bridges, especially during the rainy season. Contact between coordinators and promoters can be interrupted by these extreme

conditions. This is particularly acute in the region bordering the Nyungwe forest.

RESPONSE: To address the issue, the CSP is trying to encourage community participation in improving roads and infrastructure, by using the 'Umuganda', or 'community work' concept that is common in Rwanda.

2. Availability of ORS

CHALLENGE: One objective of the Diarrhea and Hygiene intervention is to increase consumption of ORS in case of diarrhea. ORS is currently available from MOH health centers at 50 frw per packet (and at the central pharmacy in Kigali for 31 frw) but they had been previously distributed by the MOH at no cost. During discussions concerning the first curriculum, the KHD expressed concern about whether or not the population would be willing to pay for ORS. It was suggested that the CSP could distribute/sell ORS through the volunteer network. The selling price would progressively increase every year to reach the Health Center price by the final year of the project.

The CSP had not budgeted for purchase of ORS and does not want to subsidize the cost if the population is willing and able to pay. Another challenge in distributing ORS through the volunteers is the question of who will manage the inventory and money. Unlike items such as ITNs and "Safe Water" ORS must be available in the community on an emergency basis. Leaving the supply with the promoter would not be sufficient since the promoter meets each Care Group on average only once every two weeks.

RESPONSE: As no provision for procurement of ORS was included in the CSP budget, the Program Manager contacted different organizations including UNICEF, USAID, the WHO, and MOH to assess the possibility of getting ORS at low or no cost, but no stock appears to be available through these sources for the region of Cyangugu. Further to this, a qualitative population survey was completed by the CS staff in the project area to assess whether the community is willing and/or able to purchase ORS at the MOH price of 50 FRW. Results show that the population would be prepared to buy ORS between 20 and 30 frw per packet. Umucyo is continuing to evaluate the advantages of making ORS available at a reduced cost vs. focusing emphasis on home available fluids as a more affordable alternative.

3. Volunteer expectations

CHALLENGE: Although volunteers were elected following a thorough explanation of the voluntary status of the position, it has become apparent that many of them had some expectations for compensation such as being paid per diems or other material benefits. Voluntary service is common in Rwanda, but many so-called "volunteers" including the MOH's health animators get a per diem to cover food, transportation and other expenses when they attend a meeting or a training (they receive an average of 500-1,000 frw i.e. between 1 or 2 USD per day). The saturation of NGO activity in Rwanda has also fueled these expectations. WR has faced such expectations at the start of other CSP programs but does recognize the unique issues facing post-genocide Rwanda that can affect volunteerism. In addition, the level of trust required between individuals to participate in a Care Group can be particularly difficult to develop. Yet once this trust is cultivated, the Care Group network could be of inestimable value in strengthening the social fabric of Rwanda.

RESPONSE: The WR approach to volunteer-based work does not allow for the provision of per diems or other direct financial compensation that jeopardizes true volunteer commitment and sustainability beyond the life of the project. Furthermore, it would be impossible for the CSP to compensate 2,889 volunteers financially, in addition to completing program activities. We do acknowledge the importance of recognition and encouragement of our volunteers. Volunteers are publicly recognized and small, non-cash incentives are given for each year of participation.

The staff is currently planning a recognition ceremony at the promoter level for participating volunteers that will take place in January 2003. Each active volunteer will receive a T-shirt with the inscription 'Ubuzima bwiza iwacu' or 'A good health at home'. This T-shirt will serve to affirm the volunteer's identity as a contributing member of the community. During the recognition ceremony, it will be publicly stated that volunteers do not receive per diems or other compensation It is important that the public understand the true status and commitment of the volunteers for trust, transparency, and fostering a genuine appreciation. It is suggested that incentives for future years be items such as matching kitenge or a head scarf that will further reinforce identify with the CSP while increasing the esteem of the volunteer.

Another recommendation that has emerged from the Care Groups themselves is for the volunteers to create "associations", such as a community saving group, at their own initiative that would provide support during difficult times. At this time, the CSP is not able to provide any form of technical assistance to these associations, as the CSP interventions require the staff's full attention. It may be possible in years 4 or 5, when the interventions are being reviewed a second time, for WRR to draw on its experience in community banking/economic strengthening through the Urwego community-banking program to offer some training or other support. We are careful not to promise assistance but try to encourage the group initiatives.

4. Assistance for Program Manager.
CHALLENGE: It has grown increasingly evident that the Program Manager needs assistance to address the volume of work created by the CSP in order to ensure that the CSP is adhering to the work plan schedule. The Administrative Assistant oversees logistical matters and carries out some supervision, but complete responsibility for overseeing staff management, curriculum development, networking and reporting is carried by the Program Manager. She has not been able to visit the field more than one or two times each month due to the burden of reporting and administrative needs.

RESPONSE: The CSP has recently recruited an Assistant Program Manager to work with the Program Manager. The new Assistant Program Manager, formerly area coordinator in the Yove region, has extensive community health and field experience as well as strong leadership skills. He will assume responsibility for supervising all field activities (coordinators, promoters and volunteers) and reporting on field activities beginning 1 November 2002. The Assistant Program Manager will also share responsibility for coordinating the curriculum development process. This will free the Program Manager to address some of the overarching issues of strategy, local partnerships, quality assurance and sustainability that to date have not received consistent attention.

5. Strengthening relationships with the KHD
CHALLENGE: Establishing good relationships with the KHD is key to the success of the project and to its long-term sustainability. The CSP has consistently gone to the KHD to seek feedback on interventions and the program approach. However, we feel that relationships between Umucyo and the KHD could be further improved to reach the full potential of the program. At the start of the program, the CSP staff was invited to 2 or 3 times to the KHD monthly meetings, but has not been included recently. Because of the KHD director's busy schedule, it is difficult for the CSP director to seek her input on curriculum, or for them to plan strategy together. Other staff members from the KHD refuse to attend meetings called by the CSP unless they are paid a $5-10 per diem per meeting. In addition, long standing personal relationships between some of CSP and KHD staff either positively or negatively impact the partnership.

RESPONSE: WRR Program Coordinator and Country Director will schedule a meeting with the Head of the KHD to discuss how relationships could be further improved. Results will be discussed with the Program Manager to identify what will be done. In addition to this, WRR will consider the requests made by the KHD representative during the presentation of the immunization curriculum. Some requests including provision of motorcycles and petrol for outreach and repair of cold chain equipment were discussed in the DIP and can be readily approved. Others such as the payment of per diems for KHD must be discussed further. It is important that the KHD sees the CSP as a partner in their work.

6. Quality Assurance w/ Memisa
CHALLENGE: As discussed in the DIP, the Dutch group Memisa/Cordaid has been mandated by the Rwandan government to oversee the decentralization of the health system in Cyangugu Province. Umucyo's strategy for improving quality of care at the facility level and among KHD staff must be developed with and approved by Memisa. Memisa's mandate includes responsibility for training of MOH staff in topics relating to the CSP interventions such as HIV/AIDS and maternal care. This process has been delayed as Memisa was working to develop their own strategic plan for 2003-2008. The new strategy document was only disclosed to the CSP in mid-October 2002 and now discussions can begin.

RESPONSE: The Umucyo Program Manager will schedule another meeting with Memisa to discuss quality of care issues relating to the next interventions. Overall strategy for cooperation between Memisa and the CSP will also be discussed and results submitted to WRHQ. The CSP team has been encouraged by the response of Memisa in recent months as previously there appeared to be lack of synergy between the groups.

C. NEED FOR TECHNICAL ASSISTANCE

The top priority for technical assistance has been identified as the need for training the Program Manager, Assistant Program Manager, ACs and Promoters in curriculum development and adult education/communication skills. The Child Survival Specialist has contacted Robb Davis, a Master Trainer from Freedom from Hunger, who has extensive experience in community-based health education in Africa. Tentative plans are in place for Rob to join the WR CSP and other Rwanda-based CSPs including IRC and CW for a joint training on curriculum development and adult education in January 2003. The WR CS Specialist has been in contact with Emmanuel

D'Harcourt of IRC and Michelle Kouletio of CW about the possibility of joint training, to determine what the common training needs are and how best to address them.

The CSP field staff has also requested technical assistance in the Hearth approach to rehabilitate malnourished children, which is part of the nutrition intervention scheduled to begin in October 2003. If financially and logistically possible, the project will contract Dr. Gretchen Berggren, former WR Director of Maternal Child Health (MCH) and pioneer of the Hearth approach in Bangladesh, Haiti and Vietnam. Alternatively, a former WR Vurhonga CSP staff member with experience conducting Hearth in Mozambique also may assist.

The Program Manager, Assistant Program Manager and office staff need to improve their computer skills to increase the efficiency of their work. Several staff members have also expressed a desire to improve their English skills. If possible, WRR would like to find a volunteer from the US or other English-speaking nation to assist in both English language and computer skills. One possible volunteer candidate has been identified and the logistics are being explored.

D. CHANGES FROM DIP

The following modifications to the DIP were implemented during year one:

Geographical extension
As mentioned in the Section A, the project catchment area was extended to include two additional sectors of the Administrative District of Rusenyi in Kibuye Province. The revised zone became effective following approval of WR HQ with the consent of USAID/Washington. Two additional promoters were hired to cover the additional "de facto" area of KHD.

Change in name of CSP regions
The names initially given to the CSP regions were based on structure of the MOH system and the local Health Centers. Shortly after the start of the CSP, a new Health Center was built in Karambi, in the CSP region originally called 'Gatare'. Given that this new Health Center will serve the majority of the population in the region, the CSP decided to rename the region 'Karambi". The region initially called 'Hanika' was renamed 'Gatare'. In summary, the 6 regions of the CSP are: Yove, Rangoro, Nyamasheke, Gatare, Ruheru and Karambi.

Number of volunteers
The number of volunteers now significantly exceeds the initial plans (there are currently 2,898 volunteers instead of 1,000) for the following reasons:

- Local administrative authorities demanded that our nyumba kumis correspond to the local administrative units already implemented in the region. This required modifying our plans before the volunteers' election in order to select one volunteer per nyumba kumi of 10 households.
- Extending the project to the Rusenyi district in the Kibuye Province increased the total number of volunteers by 151.

E. RESPONSE TO DIP REVIEW

At the beginning of June 2002, the Program Manager and CSP Specialist participated in the DIP review at USAID HQ in Washington DC. Four points were identified for clarification in the First Annual Report. These issues are addressed below.

1. Identification of Key Behavior Change Messages

Two new CSPs (WR and CW) were funded in Rwanda in FY 2002, joining two other projects in country sponsored by IRC and PSI. The small size of the country and shared local language make it possible for these Rwanda-based CSPs to collaborate when addressing common concerns. During the DIP review, CW was given the responsibility of overseeing the creation of common indicators to be shared by all CSPs working in country. WR was charged with overseeing the identification of Key Behavior Change Messages that also can be shared by the CSPs working in country. This approach enables each NGO to take advantage of existing materials developed by the CSPs and other USAID partners rather than investing in recreating materials.

Following the DIP review, regular coordination meetings for the CSPs began in July 2002 with revision of common indicators being given first priority. Ten indicators have been identified so far and a detailed document defining each indicator is being finalized by the local USAID mission (See Annex B for draft document).

Beginning in November 2002, the focus of the monthly meetings will be on identification of key behavior change messages. WR will oversee the process and designate partners responsible for the various interventions. Each contributor will present their findings to the group for feedback and revision.

Based on the intervention mix and expertise of each contributor, the following approach has been proposed by WR:

Intervention	NGOs with intervention	NGO Responsible	Other resources	Comments
Diarrhea & Hygiene	WR	WR		See Section A – Program Achievements for messages
Immunization	WR, CW	WR		See Section A – Program Achievements for lessons
HIV/AIDS	WR, CW	WR/CW	Facing AIDS Together, developed by WR and FFH	WR's focus is on prevention, care and reducing stigma while CW focuses on clinical testing
Malaria	WR, IRC, CW, PSI	PSI	Malaria Action Coalition sponsored by Rollback Malaria, Freedom from Hunger materials	
Nutrition	WR, IRC, CW	CW	UNICEF BCC	WR expertise in Hearth

			materials	
Maternal Care	WR, IRC, CW	IRC		IRC already completed extensive work in Maternal Care

2. Clarification of Hearth and other positive deviant interventions

The nutrition intervention is scheduled to begin in September 2003. According to the DIP, the intervention will focus on 1) Prevention of malnutrition by promoting exclusive breastfeeding, age-appropriate complementary weaning foods, and adequate child nutrition and 2) Rehabilitation of malnourished children by the community using Hearth.

At the time of the DIP review there was some confusion regarding whether the intervention would be carried out at the community level or if the Hearth intervention would be somehow be adapted to use at the clinical level and involve Nutrition Center staff members. Some KHD staff expressed concern that the rehabilitation of children at the community level via Hearth would undermine the activities of the MOH-mandated Nutrition Centers at the few facilities that have them. They wanted to hold some of the Hearth sessions at the Nutrition Centers to ensure the Center would continue to be used.

It has been confirmed with the Program Manager that the Hearth intervention must remain at the community level and be carried out in the volunteer's villages rather than at the Nutrition Center level. Nutrition Center staff will be invited to observe and participate in the Hearth session.

As discussed in Section C, WR intends to hire a consultant for the nutrition intervention with experience in Hearth during the development phase of the intervention in early FY2004. This person will train the CSP team in how to conduct a positive deviance inquiry and help develop the behavior change messages for the rest of the nutrition intervention, ensuring that the program focuses not only on rehabilitation of malnourished children but prevention of malnutrition.

3. Revision of indicators and immunization targets

Based on input from the DIP reviewers and discussions with the CSP team, the following changes are proposed for the indicators and targets.

<u>Immunization</u>

DIP objective:
75% of children will be completely immunized by year of age for polio, DPT, TT and measles. Midterm: 60%

Revised objective:
80% of children will be completely immunized (BCG, Polio, DPT-HB-Hib, Measles) by their first birthday . Midterm: 70%

The baseline KPC showed less than 50% of children in the project area being fully immunized

by age 1 and therefore the target was set lower, at 75%. One of the DIP reviewers suggested increasing the target to at least match or exceed the national average of 76% (DHS 2000). Upon further discussion, the CSP agreed, acknowledging that the low coverage at baseline could likely be attributed partly to lack of immunization cards rather than lack of immunizations. Since the program will address the issue of cards, it is very likely that we can reach the higher goal. The list of vaccines considered "completely immunized" was revised to be consistent with MOH policy.

DIP objective:
Increase from 43.8% to 50% of pregnant women in project area who will receive at least 2 doses of TT before the birth of a child. Midterm: 45%

Revised objective:
Increase from 43.8% to **55%** of pregnant women in project area who will receive at least 2 doses of TT before the birth of a child. Midterm: 50%

As pointed out by the DIP reviewer, the DIP target of 50% actually fell within the confidence limits of the baseline 43.8% reported in the KPC. Theoretically, it is possible there was no real change from baseline even if the target is achieved. Therefore the target should be increased to a more ambitious 55%.

Malaria

DIP objective:
"Increase from 3.7% to 50% the children with fever (suspected malaria) whose caretakers will seek treatment for them within 24 hours at a health facility" Midterm:20%

Revised objective:
Increase from 3.7% to **20%** the children with fever (suspected malaria) whose caretakers will seek treatment for them within 24 hours at a health facility" Midterm: 15%

Concern was expressed by several reviewers over whether or not treatment at health centers is a realistic expectation considering the limited human resources of the MOH system. According to reviewer Michel Pacques of CSTS, if children average 3-6 malaria cases per year as reported, then based on the number of children under 5 in the project area one in every three of the 36 nurses in KHD would be occupied with seeing malaria cases full time every day if they were to seek care at the facility. He questions "Does Rwanda have the human resources available to seriously implement (or even enforce) this policy?" and finds fault in the MOH policy rather than the proposed approach of WR.

Based on these observations, WR has reduced the target from 50% to 20% to reflect the current reality of the MOH system. We hesitate to remove the indicator entirely because there is hope that national policy might change and enable the population to access treatment from alternative sources such as trained drug sellers. This issue is discussed further below. The malaria intervention is scheduled to begin in June 2003. At that time, the CSP team will review the indicator and target again to determine if any revisions are necessary in light of potential policy

changes.

Nutrition

DIP objective:
Increase from 33.8% to 80% the children 6-59 mo. who receive Vitamin A capsules at least once per year and increase from 0.4 to 40% twice a year. Midterm: 50%, 15%

Revised objective:
a. Increase from 33.8% to 80% the children 6-59 mo. who received Vitamin A capsules at least once during the past year. Midterm: 50%
b. Increase from 0.4% to 40% the children 12-59 mo. who received Vitamin A capsules twice during the past year. Midterm: 15%

The DIP objective does not accurately reflect the fact that children under 6 months are generally not given vitamin A and therefore a child less than 12 months old is not likely to have received two doses. The objective is now expressed as two separate targets reflecting the difference in age.

DIP Objective:
Increase from 11.2% to 60% the mothers who will give same or more food to a child during illness. Midterm: 30%

Revised Objective:
Increase from 11.2% to 60% the mothers who will give same or more food, including breast milk, during illness. Midterm: 30%

The revised objective clarifies that the expectation for children less than 6 months is EBF.

4. Discussion of national malaria policy regarding treatment only in health centers

As mentioned above, the MOH policies regarding malaria treatment are being contested by various groups working in Rwanda. According to current policy, only MOH recognized health centers and national pharmacies are authorized to dispense medications for treatment of malaria. There are only 3 or 4 of these MOH-approved pharmacies in the entire KHD. By training drug sellers and other vendors to properly diagnose and dispense malaria medications, some of the excessive burden on the MOH system would be relieved and treatment would reach the most vulnerable. Current MOH policy prevents this approach.

The issue of the national Malaria policy has been discussed at the monthly CSP NGO meetings and UNICEF has been charged with representing the views of the CSPs and other NGOs in appealing to the MOH to change the policy. WR will continue to monitor the policy between now and the planning for the malaria intervention in March 2003. If the policy changes, WR will promote training of drug sellers and revise the indicator to reflect other options for treatment. If the policy remains, WR will review messages and the indicator to reflect the best option given the current reality.

F. MANAGEMENT SYSTEMS

Financial management

In FY2002, the CSP has greatly benefited from WRR's efforts to improve systems and procedures throughout programs. "Excellence in systems and procedures" is one of the four strategic directions identified for WRR. WRHQ transfers funds to WRR according to anticipated needs. Expenses in US dollars and local currency are tracked in the field separating WR funds from USAID funds. An external audit of WRR accounts including the CSP account in Cyangugu is planned for January 2003.

One of the challenges faced by World Relief Rwanda in FY 2002 was the implementation of new financial software. Quick Books was adopted by WRR Finance and Administration in April while the CSP continues to use Quicken. The transition by the CSP from Quicken to Quick Books is scheduled for November 2002. The CS accountant has already started training on the new software.

Additional steps have been taken recently to improve financial management. The CS Program Manager must now submit a monthly budget to Kigali Administration and Finance that reviews and coordinates the needs for funds. Moreover, in order to better manage the budget, Kigali Finance and Administration is in the process of modifying the current WR chart of accounts to more accurately reflect CSP budget line items and will start producing a local quarterly pipeline reports showing actual expenses versus budget in FY 2003.

Human Resources

A revised organizational chart for World Relief and the Umucyo project is presented in Annex C. As described earlier the Kibogora-based team is composed of the Program Manager, the Administrative Assistant, the Accountant and the Assistant Program Manager who supervises the field team, i.e. 6 area coordinators and 32 promoters.

World Relief's matrix structure provides support to the CSP from two complementary approaches: the WRR country office in Kigali provides general program management, administrative oversight and financial management and the WRHQ technical team offers specific technical support relating to program approach and interventions. Melanie Morrow, MPH, Child Survival Specialist, is the primary WRHQ contact for the CSP team.

Since August 2002, the Program Manager has reported to the newly created position of WRR Program Coordinator. The WRR Program Coordinator reports to the WRR Country Director and provides additional support and accountability in management issues.

The WRHQ technical team visited *Umucyo* three times during year one to monitor progress and provide technical support to the program. In October 2002, the CSP Specialist visited the program to assist with issues relating to program start-up. In January 2002, she returned for three

weeks to assist the CSP team in preparing the DIP. In April 2002, following submission of the DIP, the Director of MCH, came to discuss the use of the DIP and assess the need for further technical support.

Concerning reporting, a monthly report including both a narrative section on activities completed/planned and a financial report is completed by the CSP staff and sent to WR Rwanda in Kigali for editing, translation and review before being sent WRHQ. Other reports produced by the CSP include quarterly activity reports to local partners (prefecture, district authorities, MOH).

The training conducted by Dr. Kagubare in August 2002 focused among other things on the improvement of supervision tools. As a result, supervision forms were finalized to monitor field activities (see Annex A): promoters, coordinators and supervisors fill in bi-weekly time sheets with activities planned and activities completed. The planning is based on objectives specific to each position (i.e. - number of training sessions in Care Groups, number of home visits for promoters, number of supervision visits, etc.). In addition to these planning forms, forms are used during supportive supervision visits to assess the quality of training in Care Groups and at the household level.

In addition to forms and reports, promoters meet twice a month with the AC and the other promoters in their area to review Communication and Behavior Change messages to be shared with Care Groups during the rest of the fortnight and any challenges they may be facing in the communities. The 32 project promoters meet with each of their Care Groups twice a month to train the volunteers for each CS intervention (one module per meeting). As mentioned above, the ACs, the Program Manager and the Advisor conduct regular field visits to monitor results and methodologies. According to supervision reports, 60% of Care Groups were visited by a supervisor during the first intervention.

The Program Manager meets with the ACs two Fridays each month to discuss the progress of the program and share concerns. During the first year of the program, the Program Manager also met with promoters on a monthly basis to provide some training and extra support. In year two, the ACs will be responsible for all training and supervision of Promoters.

In regards to staff evaluation, WRR recently introduced performance-based reviews that will be effective in FY 2003. Every staff member is assessed by his/her supervisor twice a year and salaries are reviewed on an annual basis based on past performance against objectives. The standard appraisal form from WRHQ is used for administrative staff and ACs. The appraisal form for Promoters needs to be finalized as a review will be conducted on their first employment anniversary. The evaluation of promoters will be more directly related to the tasks they are required to complete and the performance of Care Groups under their supervision on LRAs. Staff turnover has not been an issue to the program as all staff initially hired are still working for the program.

Communication system and team development

Ability to communicate with Kigali and beyond was greatly improved in July 2002 when

Kibogora received mobile phone access (thanks in a large part to the former local USAID head of mission). Email is still done on a weekly basis from Cyangugu town - approximately one-hour drive from Kibogora but now urgent information can be passed by phone rather than relying on radio.

Team development is discussed in Section A above.

Relationships with local partners

During the first six months of the program, a significant amount of time was invested to contact local partners to present the program and discuss potential areas of synergy. Discussions confirmed that the program met the needs of the population and most local partners encouraged the approach. Contacts included representatives from the MOH, government and civil society:

- The MOH, the regional health authorities, the KHD, the Director of the KH
- The Ministry of Social Administration, the province administrative and political authorities, the Mayors of Gatare and Nyamasheke Districts, the coordinators of administrative sectors and cells
- Non-Governmental Organizations (NGOs) and other projects in the region such as MEMISA/ CORDAID that support the local health facilities as well as IRC and SNV that work in the Cyangugu Province
- The local mission of USAID
- Local religious leaders.

Collaboration in country with other PVOs

As mentioned in Section A, *Umucyo* is an active member of the CSP network that includes USAID-funded PVOs and partners (IRC, Concern, PSI, Unicef, MOH, USAID and WRR) and meets in Kigali on a monthly basis. These meetings provide opportunities to discuss common issues and share information on the programs.

Umucyo Project Manager and ACs visited IRC's CSP in Kibungo that started a few years ago in order to learn from their experience. The visit was very successful and particularly encouraging regarding the work with volunteers and traditional birth attendants. *Umucyo* received the visit of the Concern CSP staff (Kibilizi, Butare province) in March 2002.

Umucyo has also begun negotiating a partnership with PSI on the malaria intervention planned in FY 2003. The CSP volunteers will distribute PSI bed nets and the CSP will benefit from Behavior Change Communication material that PSI recently developed. *Umucyo* also started discussing the potential leverage of the new Malaria Action Coalition supported by the Roll-Back Malaria initiative with the local USAID mission. This partnership could potentially provide assistance in terms of BCC, performance improvement, and implementation of pilot projects.

ANNEXES

A. Monitoring and Evaluation Tools

B. Draft of shared CSP indictors

C. Revised Organizational Chart

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MONTHLY TRACKING OF VOLUNTEERS' ATTENDANCE TO CARE GROUPS

Promoter: **Month:**

No Care Group	No	Name of volunteer	Date																%
	Legende: X=Present,M=Probleme de sante,O=Absent																		

MONTHLY DATA COLLECTION FORM (completed by promoters)

REGION :……………………………………. SECTOR :…………………………….

PROMOTER:…………………………………………………………. Month:………………………..

Date	Care Group	Number of Diarrhea cases (children under 5)	Treatment at Health Center	Treatment at pharmacy	Treatment at traditional healer	No treatment	Number of trained volunteers	Module	Number of traditional healers trained	Module	Number of food salespersons trained	Module	Home visits (promoter)	Trained households	Module	Home visit (volunteer)	ORS Sold	

Observations

HOME VISIT FORM

Name: **Function:** **Month:**

Care Group	Mother visited	Latrine (B, M, O)	Compost (P , A)	ORS (P , A)	Drying table for dishes (P,A)	Nutritional condition (B,M)	Immunization status (R , I , NV)	Comments	Name of visitor/ supervisor

Legend : B=Good,M=Bad,O=Without,A=Missing,P=Present,R=Regular,I=Non regular,NV=Not vaccinated

WRR/CSP-UMUCYO

BI-MONTHLY ACTIVITY REPORT - Promoter

Promoter: **Week from……/……/……to ……/……./…….**
Motorbike plate: **Km Monday…………Km Friday…………= total km**

Date	*Morning*	*Afternoon*	*Comments*

Summary: ***Number of training sessions completed in Care Groups: …………..**
***Number of home visits completed: ………………….** ***Number of supervision visits received: ………………**

WRR/CSP-UMUCYO

BI-MONTHLY ACTIVITY REPORT - Supervisors (Program Manager/Asst. Manager)

Name: **Week from……/……/……to……/……/…….**
Vehicle/ motorbike plate: **Km Monday…… Km Friday……=……. total km**

Date	*Morning*	*Afternoon*	*Observations*

Summary: ***Number of supervision visits to promoters completed:……. *Number of supervision visits to coordinators completed:…….***
Number of home visits completed:…… *Number of visits facilitated:……

WRR/CSP-UMUCYO

BI-MONTHLY ACTIVITY REPORT - Area Coordinator

Coordinator: **Week from ……/……/……to ……/……/…….**
Motorbike plate: **Km Monday……Km Friday……=…….. total km**

Date	*Morning*	*Afternoon*	*Observations*

Summary: ***Number of supervision visits completed:…….. *Number of supervision visits received:……***
Number of home visits completed:…… *Number of promoters' meetings organized:……

WRR/CSP UMUCYO

APPRAISAL OF VOLUNTEER'S TRAINING IN HOUSEHOLDS

A. VOLUNTEER

I. Identification of volunteer

Name:……..
Gender:……Age…….
Province:……District:……..
Sector:……No Care Group:…….

II. Transmission of message **Observations**

Reminder of last message…...……./1 pts ……
Command of content ……../4 pts ……....…
Relevant message...……./4 pts ……....….
Politeness……./1 pts ……..….
Humility…….../2pts …….
Answers responding to questions..……..…/4 pts …….…....
Accurate advice……...……..…/4 pts ……

Total……/20 pts ……....

B. HOUSEHOLD VISITED

I. Identification of the mother

Name of mother:…….....……..
Name of husband:…….....
Cell:.....….….....No Care Group :.....
Profession of mother:.....Age:.....
Number of children under 5:.....

II. Knowledge about key messages received
(Mention :Very good, Good, Poor)

Can answer first question of promoter: …….
Can answer second question of promoter: …….
Can answer third question of promoter: …….

Promoter (Name and Signature)……

UMUCYO CSP-KIBOGORA

A. MONTHLY DATA COLLECTION FORM

I. Identification

1. Region:
2. Month:

II. Interventions

1. Diarrhea and Hygiene

1. Number of diarrhea cases in the region:
2. Number of diarrhea cases per Health District
3. Number of volunteers trained:
4. Number of households trained:
5. Number of religious leaders trained:
6. Number of health staff (incl. Pharmacists trained)
7. Number of traditional healers trained
8. Number of food sales persons trained
9. Number of ORS sold to households by the volunteers

2. Immunization

1. Number of volunteers trained:
2. Number of households trained:
3. Number of children immunized per household
4. Number of children immunized per immunization site
5. Number of children referred for immunization

3. HIV/ AIDS – STD

1. Number of volunteers trained
2. Number of households trained
3. Number of religious leaders trained
4. Number of women knowing at least tow symptoms of STD
5. Number of traditional healers trained

4. Malaria

1. Number of volunteers trained
2. Number of households trained
3. Number of religious leaders trained
4. Number of health staff (incl. Pharmacists trained)
5. Number of traditional healers trained
6. Number of children with suspected malaria brought to the Health Center for treatment in 24 hours
7. Number of ITNs sold to households
8. Number of children under 2 sleeping under a bednet
9. Number of pregnant women sleeping under a bednet

5. Nutrition

1. Number of volunteers trained
2. Number of households trained
3. Number of cases of malnourished children (Health District)

6. Reproductive Health

1. Number of volunteers trained
2. Number of households trained
3. Number of religious leaders trained
4. Number of traditional birth attendants trained
5. Number of home deliveries with trained traditional birth attendants
6. Number of deliveries in the health centers/ hospital
7. Number of consultations CPN 1
8. Number of consultations CPN 4

Harmonization of CSP indicators (DRAFT)

Present: USAID
UNICEF
PSI
World Relief
IRC
CONCERN

The following 10 indicators were identified as common indicators for USAID-CSP projects in Rwanda:

I. Malaria

Concerned parties: PSI, World Relief, Concern, IRC

Ref	Shared indicators	Comment
M1	% of households that have at least one treated bed net	DHS Table 1 Denominator: all households of the sample
M2	% of children under 5 who slept under a treated bed net the previous night	DHS Table 1
M3	% of pregnant women who slept under a treated bed net the previous night	Not in DHS

An additional indicator on the treatment of malaria was discussed and needs to be followed up with Quality Assurance.

II. Nutrition

Concerned parties: World Relief, Concern, IRC

Ref	Shared indicators	Comment
N1	% of children 0-23 who are –2 standard deviations of the international curve of weight for age	DHS Table 9.7
N2	% of children 6-23 months who received at least one dose of Vitamin A over the last 6 months	DHS Table 9.5 (59 months) Standard dose: 3 per year
N3	% of children 0-23 that were breastfed within one hour after delivery	DHS 9.1

III. Maternal Care

Concerned parties: World Relief, Concern, IRC

A.	B. Shared indicators	Comment
MC1	% of women who delivered at the Health Center/ hospital	DHS Table 8.5
MC2	% of women who delivered with a trained TBA	DHS Table 8.6
MC3	% of mothers that got at least 2 doses of TT during last pregnancy	DHS 8.4 – one dose

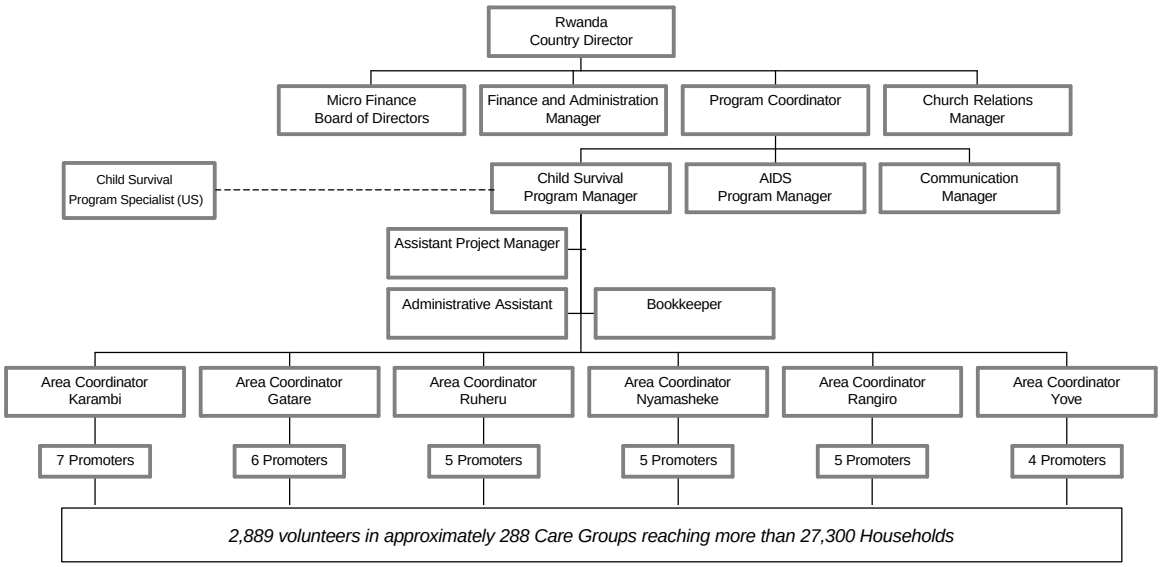
Note: Post natal care is not yet included in health center services.

IV. HIV/ AIDS

Concerned parties: World Relief, Concern

C.	D. Shared indicators	Comment
A1	% of mothers that know at least 2 common symptoms of Sexually Transmitted Diseases other than HIV/ AIDS	DHS Table 12.10.1

ORGANIZATION CHART: CHILD SURVIVAL PROJECT UMUCYO



CHILD SURVIVAL PROJECT - REGIONAL ORGANIZATION